Minutes for January 26, 2012 Meeting

Topic	Discussion & Outcome(s)
	Members present: Drs. Bishop, Carter, Chamblin, Friedman, Howe, Firestone, Harmon, Lang, Nilson, Ploss, Sullivan, Tauben, Yorioka, Waring, Zoltani **Members absent:** **L&I staff present:** Dr. Franklin, Dr. Glass, Dr. Stockbridge, Leah Hole-Curry, Simone Javaher, Reshma Kearney; for first hour: Dave Overby, Diane Reus, Gary Walker, Gayleen Lies **Members of the public present:** Bill Alkire, Ryan Guppy, Dena Scearse
Welcome and minutes approved	Minutes from 10/27/11 meeting were approved.
Update on Provider Network Advisory Group	Top tier criteria and incentives were discussed. New rule language is being proposed and is open for comment regarding workers' initial visit to providers. The hearing for this rule will be 2/23/12 at L&I. A small focus group is being convened to discuss how best to inform providers.
Provider Network Enrollment Activities	L&I will start enrolling providers incrementally January-August according to certain schedule (see slides). Providers can enroll in network at any time though, either electronically – which is preferred because it is more efficient for L&I to process and providers will have less re-work, or with a paper application. Some providers will be enrolled through "delegated credentialing." This means L&I may accept provider credentials from an accredited entity (e.g. accredited by NCQA, JCAHO, or URAC) that has already verified their credentials, although L&I will retain the right to enroll or not enroll each provider in the network. The department will ask organizations who meet the above criteria to fill out a delegation application and agreement. About 80% of providers who treat injured workers treat only 1-2 workers. Discussion on transfer: Current and newly injured workers will need to use network doctors. There is a team headed by Chuck Hitchings and Mary Kaempfe that is working on a new provider directory, populated largely from the provider application. The current Find a Doc service that L&I has does not indicate whether the provider is seeing new patients and has other limitations. It will be important for L&I to try to identify an approach to indicating whether listed providers are accepting new L&I patients because otherwise workers, claims managers and others frustration will remain high when it appears that there are provider options because they are enrolled L&I providers, but they cannot access them because the provider isn't taking new L&I patients.
Stay at Work Program	This program provides financial incentives for employers to keep workers on the job who have been injured but who can still work in some capacity e.g. light duty or transitional work. This may include partial wage replacement, tools, clothing, etc. This reduces some of the harms that can occur due to long term "worklessness." The article that was the basis for evaluating the effects of worklessness is by Waddell G, Burton K, Aylward, M in Journal of Insurance Medicine 2007;39(2): 109-120. The impact on attending providers is that there may be a renewed or increased interest in requests for light duty. APs will need to review and approve the light duty or

	transitional work assignments to see if the worker can perform the duties required. These approvals can be done through completing the Activity Prescription Form (APF), for which they can be reimbursed. See slides for references to forms, webpages, and billing codes. Contact person for questions is Michell Cartwright, at cami235@Lni.wa.gov or 360.902.4978.
Spinal Injections Policy	A summary of the Health Technology Assessment program's decision on spinal injections was presented. See www.hta.hca.wa.gov/spinal_injections.html for details (link on slides was incorrect). Therapeutic medial branch nerve blocks, therapeutic intradiscal, and therapeutic facet injections would no longer be covered. Epidural and sacro-iliac injections are covered only when certain criteria are met. L&I is planning to implement this policy by July 1, 2012. Changes will be needed in WACs, payment policies (that are in the fee schedule), and in the utilization review and authorization processes. In calendar year 2010, L&I paid over $6 million for these injections. Discussion: HTA decisions are not changeable by L&I or IIMAC, but this does need some interpretation. IIMAC members can help L&I define what constitutes "failure of conservative therapy" and "clinically meaningful improvement." L&I also need to define injection limits, especially so claim managers know what and how many to authorize (e.g # of needle sticks, levels, sides, dates of service, per claim, per patient, per 6 months etc.) Further work will be done on this and the topic will be presented again at the April IIMAC meeting.
Lumbar Fusions	Outcomes for lumbar fusions are still poor (see slides for full discussion). Presented options of either referring HTA decision back to HTA with more comprehensive questions and review, having mandatory worker/patient participation in comparative effectiveness study, or requiring hospital participation in Spine Certn or Spine Scope quality initiative as condition of payment. Blue Cross Blue Shield North Carolina as a non coverage policy but can't adopt that here in light of current HTA decision. Shared evolution of L&I fusion guideline and new studies and data that have come out. Current guideline is OK for now, but would need to be redone if changed policy. Spine Certn and Spine Scope reviewed. All supported idea of having workers participate in mandatory study on fusion effectiveness, but uncertain if we can require workers to participate. About 50-50 split in support for requiring hospitals to participate in SpineCertn or Spine Scope. One suggestion was to limit coverage policy to two fusions maximum.
Update on Chronic Pain Subcommittee	Revisited the scope of the L&I opioid guideline: chronic opioid therapy, Perioperative uses of opioids when patient on COT, tapering and detoxification, comorbidities and contraindications, co-prescription risks, and provider resources and tools. There have been many challenges to completing the tapering section due to trying to fit best medical treatment models with limits of workers' compensation system. Some sample structured taper methods were presented, a draft preamble stating the concepts and framework for the guideline, and a revised timeline were all presented. It was noted that most opioid trials last only 12 weeks and that might want to consider in preamble, the order of treating pain: a) seeking pain relief, not necessarily from medications, b) use of non-opioids, c) use of opioids.